



National American Indian & Alaska Native

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Prevention

IN OUR NATIVE AMERICAN COMMUNITIES • VOL 1 ISSUE 1 WINTER 2019

**Tobacco:
Returning to
Traditions
in Native
Communities**



DIRECTOR'S CORNER



Welcome to the second issue of Prevention in our Native American Communities, the newsletter of the National American Indian and Alaska Native Prevention Technology Transfer Center (PTTC). This newsletter is published at a time of the year when we celebrate harvest with family and friends, and high holidays in most ethnic communities. For most people these are happy times. However, for some people this is a time of loneliness and isolation, and can be a period of great temptations to use alcohol, and/or other substances to an excess. So let us be inclusive community members and reach out to our Native friends and family members. Being a good community member is our way of contributing to prevention of behavioral health issues by simply paying attention to colleagues and friends who might not have the family support many of us have.

The focus of this newsletter is on use of nicotine/tobacco; a substance often used together with other substances. Tobacco is a sacred substance in Native communities and are often included in Native ceremonies. However, tobacco used for ceremonial use is very different than tobacco included in cigarettes, chew tobacco, and pipe-tobacco. Furthermore, being a pipe-carrier is a respected position who is also often a spiritual leader, with lengthy training/education in how to use ceremonial tobacco. In addition, tobacco is used as a way of showing gratitude in interaction with Native colleagues. Tobacco should not be abused, even though we know that tobacco in cigarettes is very addictive. Hence, the main article in this newsletter focuses on prevention of tobacco abuse in Native communities. The article also includes a review of prevention efforts in tribal communities.

The gaming industry has brought resources to tribal and urban Indian communities and because of this, it is sometimes difficult to maintain a public health perspective on gaming and smoking in tribal casinos. For those reasons we have included a short overview of smoke-free tribal casinos entitled, "Smoke-free casinos: Challenges for commercial and tribal venues."

Professor Rima Afifi has done research on use of tobacco in indigenous communities in the Arab world, and she shared with us her perspective on these issues in an interview with Cindy Sagoe, B. Pharm., MPH, and Coordinator of the National AI/AN Prevention TTC.

Finally, we are proud to announce that the National American Indian and Alaska Native PTTC will publish before the holidays the third culture cards in the series called Connecting Prevention Specialists to Native Communities. The third culture card addresses sacred and ceremonial tobacco in Native American communities. This follows the previous two in the series, Culture is Prevention, and How to promote cultural connectedness as a substance abuse prevention specialist.

We always end our newsletter with our upcoming events and Sean Bear, Co-Director's Native wisdom.

With that we would all like to wish you a happy holiday with family friends and community members.

Anne Helene Skinstad, PhD



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PREVENTION OF TOBACCO ABUSE

KEN C. WINTERS, PhD
contributions from MARY K. WINTERS, MEd

Introduction

Tobacco's origins among Native American and Alaska Native (NA/AN) tribes have a common theme: as a sacred plant, tobacco is to be used with respect. Historically, tribal rituals were important to all aspects of tobacco use, from planting, harvesting, how it was stored, and the circumstances it was offered and smoked. The traditional uses of tobacco within Indian country nowadays is not what it was. The commercialization of tobacco and various nicotine products, and its use for non-spiritual purposes, now dominates Westernized cultures. Yet many NA/AN individuals and tribes use tobacco for ceremonial, religious, or medicinal purposes.²⁰ Also, stories and teachings of the spiritual uses of tobacco still has a role in Native communities, not only to foster its use in spiritual gatherings and ceremonies, but also to reduce the number of Native individuals who abuse tobacco.

Keys to Effective Prevention

It is a sobering fact that the prevalence of tobacco use among NA/AN youth and adults is the highest among all ethnic/racial groups in the US.⁷ Strengthening known effective prevention efforts provides a means to reduce this high prevalence rate. The next section provides an overview of community-level prevention strategies and approaches that have shown to be effective in discouraging the “recreational” use of tobacco products. These prevention approaches have the potential to address the problem of tobacco abuse in NA/AN country in several ways: to reduce the number of youth who initiate tobacco use; to increase the number of current users to stop; and to increase the number of abusive users to seek treatment for nicotine addiction. A reminder: This section refers to the commercial sales and recreational use and not the sacred and traditional use of tobacco.

Nicotine is the culprit

The addictive component in the leaves of the tobacco plant is nicotine. This organic compound is the highly addictive element in cigarettes, e-cigarettes, pipe tobacco, chew, and snuff. It follows alcohol in popularity of use around the globe. Whereas the proportion of US adults that report being a current smoker in 2017 was 14%, that rate is significantly down from the 21% of current smokers in 2005 and the 42% rate in 1965.¹⁹ The recent introduction of e-cigarettes and other vaping devices involves the process by which nicotine-based liquid is heated to generate an aerosol, commonly called a “vapor,” that the user inhales. Whereas all forms of delivering nicotine can lead to addiction, the inhalation forms are believed to be the most addictive. Purchasing, possessing, and using tobacco products is illegal for people under the age of eighteen in nearly all of the United States. However, some municipalities have raised the legal age to 19 or 21.

The US Surgeon General concluded in 1988 that nicotine was an addictive drug, and nicotine addiction, like all other addictions, is significantly elevated if use begins during adolescence, compared to onset of use during adulthood.¹⁸ In the 1960s, the tobacco industry understood that nicotine was an addictive drug and used its expertise in nicotine pharmacology to design nicotine products, particularly cigarettes, to maximize its addictive potential (e.g., use of agents that potentiated the effects of nicotine; use of flavors; physical construction of the cigarette). Nicotine affects similar areas of the brain involved in regulating pleasure, reward and addiction that are impacted when using other psychoactive substances that have addiction potential.⁶

Public health response

For decades, a sophisticated, politically powerful and well-resourced tobacco industry, along with advanced product engineering and marketing power, enabled tobacco products to be very popular among individuals. Worldwide, the consequential negative health impacts are devastating. Yet in recent decades, public health advocacy and policymaking has brought the tobacco industry under control. Effective public health controls were identified, applied and monitored, yielding a model of successful nicotine control programs (often noted as tobacco control policies). The outcomes were a reduction in overall consumption of nicotine, including fewer daily users, and a reduction in associated health risks associated with using nicotine products.

Following are evidence-based prevention strategies. First, an overview of the key principles from the prevention literature are summarized, followed by an overview of the most salient prevention strategies and approaches cited as crucial to the public health success in reducing nicotine use and its negative impacts.



A question in the tobacco cessation field is whether the use of e-cigarettes is a vehicle for stopping use of cigarettes. A recent study in the US found no evidence that smokers who used e-cigarettes and other electronic nicotine delivery systems (ENDS) in the United States were more likely to quit smoking cigarettes than smokers who do not use these products. The study, looking at 2015-2016 data, found that 90 percent of people who used both ENDS and traditional cigarettes (dual users) were still smoking one year later.²¹

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Barry and Glantz identified four research-based principles of effective tobacco control policies:¹

1. Prohibitions on tobacco marketing, strong graphic warning labels, aggressive media campaigns, smoke-free environments and taxation.
2. These successful strategies and policies are significantly mediated by reduced social acceptance of using nicotine products.
3. Prevention efforts aimed at youth nicotine use are more successful when adult nicotine use is concurrently addressed.
4. Minimize industry influence in the policy process.

Specific evidence-based tobacco control policies

Marketing and advertising

Given the influence of marketing and advertising, health organizations and watchdog groups recognize that the most effective strategy to protect public health would be to prohibit tobacco marketing entirely. Tobacco advertising and promotion affect awareness of smoking, recognition of specific brands, attitudes about smoking, intentions to smoke, and actual smoking behavior among individuals (including youth).²² In the US, conventional cigarettes are banned from being advertised on television/cable, radio and billboards. In addition, the FDA proposed a rule in 1996 that allowed print media advertising only if the print product's adolescent composition did not exceed a 15% threshold. Tobacco companies in the US heavily advertise in magazines where youth audience composition is near or at the minimum threshold level, thereby still exposing a sizeable number of youths to tobacco ads.⁹ However, contrary to conventional cigarettes, e-cigarettes are allowed to be advertised on television/cable and the radio in the US, an allowance that has been implicated as part of the reason e-cigarette use has increased dramatically.⁴

Youth are regularly exposed to pro-tobacco messaging through a wide variety of media channels, including static tobacco advertising on newspapers and magazines, retail outlets, the Internet, social media and in youth-rated films. The National Cancer Institute's monograph, *The Role of the Media in Promoting and Reducing Tobacco Use*,¹² concluded that the tobacco industry promotional and marketing activities has a causal relationship between tobacco marketing exposure and leading young people to take up tobacco, keeping some users from quitting, and achieving greater consumption among users. Promoting products that particularly target youth, an age group that appears to more influenced by advertising than adults, is a strategy given high priority by the nicotine industry.

Smoking cessation products, such as gum and patches, also contain nicotine. But because these products bypass the inhalation method and the nicotine potency levels in them are quite low, cessation products are generally non-addictive and can benefit a person who is trying to quit using another nicotine product.

Warning labels and pictorial warnings

A prominent source of health information regarding the risks of smoking comes from tobacco product packaging. Yet effective communication of the risks associated with use are a function of the size, prominence, position, and design of these messages. For example, warning labels that have a display size of at least 50% of the front and back sides of the package and are not limited to the sides of the package, are associated with increases in health knowledge and motivation to quit.¹⁴ Studies evaluating graphic, pictorial warning labels in other countries (e.g., Canada and Australia) are associated with greater intentions to quit and actual quit attempts.¹² Labels may also promote help-seeking by including messaging with cessation information and result in calls to quitlines to increase when packaging contains a toll-free quitline number.

Smoke-free laws

The contention that there is no risk-free level of exposure to tobacco smoke was affirmed in 2006 by the US Surgeon General.¹⁸ Second-hand smoke has been linked to a range of ailments and disorders in adults (e.g., cardiovascular disease, lung cancer, stroke, respiratory disease) and in infants (e.g., elevated risk for sudden infant death). In addition to protecting the health of the public, smoke-free laws have the additional effect of de-normalizing use of smoked products and may discourage initiation, and for current users, encourage effort to quit. Communities with comprehensive smoke-free laws have seen large drops in hospitalizations for ailments associated with tobacco use, such as heart attacks and other cardiovascular conditions.¹⁶

Mass media campaigns

The attention of this prevention strategy has been on youth, owing to the widespread finding that young people are more influenced by media messages than adults. The US Surgeon General concluded that there is sufficient evidence to infer a causal relationship between the level of funding for antismoking media campaigns and reduced smoking prevalence among youth.¹⁸ For example, one study showed that youth exposure to anti-tobacco media campaigns (e.g., The Truth Campaign) reduced the odds of current cigarette use by 15% and smokeless use by 30%, compared to students with zero media exposure.³ Anti-smoking media campaigns aimed at adults are not only effective to this age group, but youth are equally likely to report favorable responses to them.

Social norm change

Why are the strategies discussed above effective? One compelling reason is that these approaches serve to move social and institutional norms to disfavor smoking, which may motivate many individuals to resist use, or for current users to make quit attempts.

Consider the prevention approaches noted above: advertising bans de-normalize use of nicotine products; graphic and well-placed warning labels remind users of the harms of using nicotine; and point of sale product bans minimize the impact of advertising.¹ Many states (e.g., California) provide exemplary examples of a successful application of the social norm change strategy.²

Point of sale

Reducing or prohibiting the promotion and marketing of tobacco products at the point-of-sale has been shown to discourage smoking initiation and progression to smoking among both youth and adults. An additional protective factor relevant to youth is not locating stores near schools.¹⁴

Taxation

Taxation has been used to raise tobacco prices artificially in order to both discourage consumption, and to prevent non-using taxpayers from subsidizing the various regulatory, prevention programming, and health costs associated with tobacco use.¹² Experts tend to agree that the significant increase in the cost of tobacco products has been a major factor in reducing use, particularly among youth.

Family influences

Families are influential with respect to many health habits. Pro-health parenting practices include effective monitoring of all risk behaviors, setting family rules, and appropriate application of consequences. The smoking environment in the home and family management practices have been shown to be associated with risk of smoking behaviors of family members. For example, the likelihood of adolescent daily smoking is less when there is no smoking among other family members. A recent study showed that daily smoking can be reduced when parents engage in high-level family management.¹⁵ Jackson and colleagues showed that an in-home, anti-tobacco program, taught to and implemented by parents, can be effective in reducing risk of adolescent smoking initiation.⁸

In the 1990s, the majority of the attorney generals for individual states sued the major tobacco companies contending that these companies were advertising to children. The “Master Settlement Agreement” resolved the litigation, and it placed some significant restrictions on marketing to children. Subsequent to this settlement, the percent of total magazine advertisement spending for mentholated brands increased from 13% in 1998 to 76% in 2006, with an associated increase in youth mentholated cigarette smoking (8 percent per year between 2002-2006).

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A study conducted by the University of the Minnesota found that cigarettes can be purchased on NA/AN-owned Internet sites for about one fifth of the price at grocery stores, making this a more convenient, lower-priced, and appealing method of purchasing cigarettes. Researchers and educators are challenged to address this new marketing approach and to discover ways to curb rising smoking rates in Native communities.

Comprehensive strategies

A well-known principal of health related prevention programs is that comprehensive approaches are the most effective.¹³ Designing and implementing comprehensive tobacco control policies is also the gold standard in the tobacco control field. A model comprehensive program would include prohibitions or restrictions on advertising, health warning labels, smoke-free laws, pricing disincentives, and mass media campaigns.¹⁷ In US states where investment in comprehensive tobacco control programs was larger and sustained over longer periods of time (e.g., California, New York, Minnesota), the prevalence of nicotine use, particularly cigarette use, even among youth, declined more rapidly compared to states with less investment.¹⁷

Summary

Highlighted above are prevention strategies that have influenced the success of reducing the use of nicotine abuse in the US, including among NA/AN individuals. Also, the emergence of a nonsmokers' rights movement, evidence linking secondhand smoke exposure to disease, and understanding the importance of countering the actions and influence of the tobacco industry that seeks to encourage nicotine use behavior, particularly among youth, are relevant to effective implementation of these strategies.¹⁷ The more that communities and governments spend on comprehensive tobacco control programs, the greater the prevalence of non-initiators and the more rapid the decline in nicotine use among current users. The benefits of lower rates in smoking occur soon afterwards by virtue of reductions in medical costs. One study showed that a 10% relative drop in smoking is followed the following year by a 2.2% drop in medical costs.¹⁰

Going forward, there are continuing challenges with respect to the prevention of tobacco use in NA/AN communities. The expanding popularity of vaping is offsetting earlier reductions in cigarette use, particularly among youth. This is a significant concern due to the potential adverse effects of nicotine on adolescent brain development and long-term nicotine addiction. Additional policies and programs are required to help NA/AN individuals to not initiate or to reduce recreational use of nicotine products. It is encouraging that many tribes have strengthened prevention-related policies and regulations, including the prohibition of sales to minors and instituting smoke free policies. Also, sustaining cultural values and traditions by the spiritual use of tobacco in ceremonies can have a preventative effect.



Whether exposure to second-hand vaping fumes is a health risk or not is still a topic of scientific debate. Most states with smoke-free laws do not include prohibition of vaping.

Native American and Alaska Native Tobacco-Related Resources

Several resources pertaining to NA/AN use of tobacco are highlighted below.

Tobacco Prevention: <https://www.ihs.gov/hpdp/tobaccoprevention/> - Indian Health Services provides a range of NA/AN pertinent information on the epidemiology, prevention and treatment of tobacco use.

American Indians and Alaska Natives and Tobacco Use: <https://www.cdc.gov/tobacco/disparities/american-indians/index.htm> - A comprehensive source of information on tobacco use, prevention and treatment for NA/AN communities, authored by the Centers for Disease Control and Prevention (DHHS).

Native Americans and Tobacco Use Factsheet: <https://www.tobaccofreekids.org/assets/factsheets/0251.pdf> - This fact sheet provides an overview of the extent of the problem of tobacco use among NA/AN individuals and resources for prevention and treatment.

Tobacco 101: <http://www.npaihb.org/wpfb-file/tobacco-101-ppt/> - This PowerPoint file from the Northwest Portland Area Indian Health Board includes basic facts about nicotine addiction, prevention and treatment relevant to NA/AN individuals and communities.

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Smoke-Free Casinos: Challenges for Commercial and Tribal Venues

KEN C. WINTERS, PhD

contributions from MARY K. WINTERS, MEd

Tribal sovereignty exempts tribal casinos from statewide smoking bans, unless the state law is included in the Compact agreement. There are smoke-free tribal gambling facilities in the US, and some have done so voluntarily. But as is the case with commercial casinos, this is the exception not the norm.

What are the health risks of casinos that allow smoking? Health concerns exist for casino patrons, as well as employees who work for eight or more hours daily on casino floors. Even casino workers in a “well ventilated” casino have cotinine (metabolized nicotine) levels 300-600% higher than in other workplaces during a work shift.³ Just considering traditional (combustible) cigarette use, an estimated 50,000 Americans will die each year because of secondhand smoke exposure.²

Do smoke-free casinos suffer a loss of patronage? It is unlikely that this is the case. Nearly 1000 patrons of the Lake of the Torches Resort Casino in Lac du Flambeau, Wisconsin were assessed in 2011 regarding their future patronage of a smoke-free casino: 54% patrons were likely to visit more, 18% patrons to visit less, and 28% indicated it would have no effect.¹ Also relevant is the fact that smoking is not common among Americans in general, and also very uncommon among casino patrons. One study showed that fewer than 10% of patrons smoked during any of the 22 total casino visits by the researchers, and all peer-reviewed economic studies have shown that casino business remains the same or improves after the implementation of a smoke-free law or rule.⁴

According to the American Nonsmokers’ Rights Foundation, as of 2019, 8 tribal casinos are 100% smoke-free (3 in California, 2 in New York, and 1 each in Massachusetts, New Mexico and Wisconsin.⁴ Vaping restrictions are starting to be recognized as well. An example is Wisconsin’s Ho-Chunk Gaming Madison. In 2019, it banned e-cigarette use and vaping inside the venue, adding to its existing ban on other tobacco products.

The tobacco industry

There are concerns that the tobacco industry sees tribal casinos as an easy avenue to promote tobacco products. Yet commercial tobacco use is distinct from sacred tobacco use. Prohibiting commercial tobacco smoke does not diminish the sacred status of traditional tobacco and its ceremonial cultural uses. By offering a smoke-free environment, patrons and employees are protected.

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UPCOMING ACTIVITIES & EVENTS



Date	Event	Location
1/13-14	Spirit of Communication Motivational Interviewing Training	McKinleyville, CA
1/21-23	ORN Opioid Prevention Thought Leader Meeting: Strategies Used by the Prevention Workforce - <i>staff will be attending this meeting</i>	Phoenix, AZ
2/2-6	Community Anti-Drug Coalitions of America 29th Annual National Leadership Forum & SAMHSA's 15th Prevention Day	National Harbour, MD
Feb TBA	Substance Abuse Prevention Skills Training	Sacramento, CA
2/26-28	Leadership Academy Enhancement Session	Albuquerque, NM
3/17-19	National Indian Health Board 2020 National Tribal Public Health Summit	Omaha, NE
3/30-4/3	GONA Training	New Mexico
4/16-18	Spirit of Communication Motivational Interviewing Training	TBA
Apr - TBA	Substance Abuse Prevention Skills Training	Jemez Pueblo, NM
May - TBA	Cultural Sensitivity Training consensus panel	Iowa City, IA

For additional events in our Prevention and Addiction programs, please visit their websites: MHTTC: mhccnetwork.org/native; ATTC: attcnetwork.org/native

Uplifting Positive and Protective Factors in Commercial Tobacco Prevention Efforts



A conversation with Rima Afifi, PhD, MPH

Professor and Interim Departmental Chair, Department of Community and Behavioral Health at the College of Public Health, the University of Iowa

by Cindy Sagoe, B Pharm, MPH

To support efforts towards commercial tobacco prevention in Native communities, sharing best practices and experience from the work in other communities has been essential in driving program development, implementation and policy change. To share some of these best practices and approaches, we met with Dr. Rima Afifi to discuss her work and experience in commercial tobacco prevention and youth wellbeing in Arab cultures in Lebanon and the Arab region. Dr. Rima Afifi is a professor and interim department chair in the Department of Community and Behavioral Health at the College of Public Health at the University of Iowa. Prior to that, she was a professor in the Department of Health Promotion & Community Health and Associate Dean of the Faculty of Health Sciences (FHS) at the American University of Beirut (AUB) in Lebanon. Rima's research interests and practice fall into four broad categories: tobacco control, youth well-being, protective factors among youth and intervention evaluation. Within these areas, whenever possible, she uses methods of Community-Based Participatory Research which gives marginalized communities voice and opportunities for self-determination. Rima is committed to social justice and equity globally and thus advocates for a focus on the social and structural determinants of well-being to promote inclusion, equity, and justice. She has infused her research and practice with critical reflections on the impact of global forces, and conflict as well as the power of youth agency and voice. She has authored over 85 peer-reviewed publications and has engaged in extensive professional practice in the Arab region and the United States.

Cindy Sagoe: Thank you for speaking with us Dr. Afifi, please tell us about yourself.

RA: My name is Rima Afifi, I identify as Arab mostly; my mother is American, my father is Palestinian, but I was born and raised in Beirut, Lebanon and lived there most of my life. I have been in Iowa since July of 2017 but prior to that my work had been at the American University in Beirut for the last 20 years. I have three children, all grown, all girls and I am currently a professor in the Department of Community and Behavioral Health at the College of Public Health and serving on an interim basis as the department chair.

CS: Thank you for sharing about yourself. Getting into your work interest, what do you do and how did you get into the field of public health?

RA: Most of what I do is what I would call public health in general and mostly in the area of community health. A lot of my work is with young people and I started off some 20 years ago with a traditional public health approach, in that I was focusing mostly on risk factors and behavioral health issues that had higher prevalence in youth communities, looking at some of the ways we can create environments that are more conducive to health than to illness. However, the more I worked in that risk behavior model, the more I realized it may not be the most efficient model. I started to think about an alternative approach, which is the protective factors model; anything related to assets, positive factors, looking at things from a positive perspective and how a focus on the positive can often help prevent many negatives - as opposed to when we focus on the risks, in which case we focus on each one alone and that might not be the most effective strategy.

It's difficult to take an approach of completely positive protective factors because much of our funding across the world is focused on diseases and illness, not on health. However, whenever possible, even if the grants we receive are illness related, we try to paradigm shift so that we're working first in a participatory manner with people and second on uplifting positives rather than focusing on deficits.

I got into tobacco research and prevention efforts because at the time I was doing my dissertation, tobacco was a pretty big risk factor for young people and though it wasn't necessarily causing health issues in young people, it was causing the majority of death and disease in older people. So people were starting to look back at the behaviors people are taking up at young ages that influence our ability to stay healthy at older ages - looking at it from a life course approach.

I've continued doing that work but shifted from looking specifically at individual factors to focusing much more at upper level factors. Like how do we create communities and environments that are more health-producing and create opportunities for people to choose healthy ways of living rather than trying to fix individuals? Fixing individuals doesn't change the number of individuals that continue to experience and use tobacco.

CS: Very interesting that some of the key things that stood out included looking at the issues from a protective perspective or the positive rather than risk or negative factors; being more proactive rather than reactive in problem solving. That is one of the pillars of prevention and is very important when we work with Native American and Alaska Native communities to remember that the Native culture and values are resilient and so protective.

RA: I think the other thing to think about, because this has affected a lot of what's happening in Native communities, is to think about the ecological approach and not to focus as much on individuals but more on what factors at the various levels above the individuals (organizations, communities, policies, structures) that are influencing individuals and working to change those factors. So, to focus on all the oppressive systems that have caused a lot of the issues that Native communities are facing right now.

CS: Tell us your experience in some of the places and communities you have worked and if you see the parallels with Native American communities?

RA: As I mentioned, most of my work has been in the Arab world, and interestingly enough, with hookah as an alternative tobacco product. Cigarettes are used quite frequently in the Arab world, mostly by men. But one of the unique tobacco products that has a base in the Arab world and then became an epidemic across the world is the water pipe or hookah and so we started to do a lot of work trying to understand what that product was, what the economy behind it was, as well as the attractiveness of the product. This would allow us to develop interventions to influence smoking prevention and control - particularly among young people who are choosing hookah over cigarettes. Perhaps there's been some success in our messaging on cigarettes and the dangers of cigarettes. However, we had not done a good job on hookah globally.

At the same time, because the environment in Lebanon was such a positive smoking environment, we also felt like we had to do a lot of policy-related work and so we worked with a lot of stakeholders to put forth a tobacco prevention and control policy or law that was mostly about ensuring smoke-free public places or banning advertisements for commercial tobacco and increasing warnings on tobacco products, trying to raise taxes on commercial tobacco products. The law passed with support of a lot of stakeholders. Because it's such a complex problem, it not something any one person can do, and it does have to come from a community's desire to act.



"...how do we create communities and environments that are more health-producing and create opportunities for people to choose healthy ways of living rather than trying to fix individuals?"



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I think the similarities of that context for commercial tobacco control and that of Native communities is that - in general - the developing world has been targeted by big tobacco very much like the Native communities have been targeted. The strategies that have been used to oppress and control by these big multi-national companies are very similar and they seem to be outside global legal mechanisms. Native communities are justifiably sovereign, and I think big tobacco sees that as a plus for them.

The revenue from tobacco sales that come to the state - in this case, to the tribal communities - is quite high and these marginalized communities may not have many options in terms of revenue. That fact makes the tobacco companies very powerful in negotiation with governments. Public health often does not have the same kind of money, power, and lobbying.

CS: You mentioned some policies that were implemented in the course of your work in tobacco prevention, can you tell us about some success stories?

RA: The policy change was very interesting. What happened was that the legislature put forward a tobacco prevention and control law in Lebanon that was not evidence-based; so, for example, it had provisions for smoking and non-smoking areas in public places; which we know don't work at all. The World Health Organization (WHO) Framework Convention for Tobacco Control (FCTC) is the first global health treaty ever and the nice thing about that treaty is that the evidence-based policies are laid out. You can go to the FCTC document and see what has worked globally. In Lebanon, we took the law as originally drafted and tried to make it evidence-based in line with the FCTC. We did it in partnership with non-governmental organizations (NGOs) and the media. The reason these partnerships were effective is that each of

these institutions had a role to play, for example, there are often things that academic institutions can't say; you can get political but not too political. We (the academics) could put across the evidence and the media can take that up and reach a large public as well as do a lot of shaming and blaming, while the NGOs can advocate and push forward. The passage of these types of laws only work when everyone works together; because no one can do it alone.

Coalition building takes effort and time to be effective. There needs to be discussion and debate about what the best outcome is that the coalition wants to achieve, and what that outcome looks like. We did agree to let go of taxation, for example, because we figured if we tried to increase taxes within that law we would lose completely; though we knew taxation is the number one effective prevention measure for tobacco use in youth. There are these decisions that need to be taken, and where to draw the line is not an easy choice. Academia is not an ideal place to carry out policy-related work because policy-related work doesn't happen on an academic schedule.

The other thing that is hard about policy work is that it's never-ending. Just because we've passed a policy doesn't mean you can stop because there's also the implementation process. So, this policy was passed and implemented well for the first three months, and then basically the government just let it go. If you look at the situation of tobacco use in public places in Lebanon now, it's definitely better than it was 8 years ago, but it's not where we would want it to be. I think we would consider it a success, and now the work is on ensuring that the law is implemented well and enforced.

Part of the real complexity is finances. There are always these debates, “We will lose money from tourism or something else if we pass this law.” If the government bodies are worried about losing revenue, then they’re quickly going to give up a law. There is also a tobacco company in Lebanon who is always pushing against any regulation. There are all sorts of politics happening and power is often not with public health. It’s challenging but it’s very important work.

CS: Native communities face some of these challenges with communities and coalitions advocating and working on prevention efforts and trying to balance the role of tobacco in their culture at the same time the tobacco companies continue to exploit the role of tobacco in the Native culture as a marketing strategy.

RA: Right. A unique aspect of Native communities is that tobacco does have a role in cultural traditions. The cultural traditions around tobacco are not commercial, but in the taking over of the Native communities’ land, and as a result of oppression, there was an imposition of laws and a lot of control of Native customs, including rules about not being able to use traditional tobacco. We do need to consider what our strategies around commercial tobacco control should be in Native communities, strategies that keep the traditional tobacco custom and culture, that engage Native communities in deciding what works for them and how it works for them, and that makes a distinction between traditional and commercial tobacco.

There is an interesting paper I read by Native authors that was about all these challenges and complexities of tobacco in Native communities, and how to move forward positive tobacco prevention, as well as how to move forward with health as an objective when you know commercial tobacco is causing so much illness and death. So, how do you protect health but not at the expense of culture and tradition? Those are complex conversations, but important. Looking at the term “tobacco prevention and control,” we use that term all the time, but it may be perceived very differently in Native communities from other communities. That word “control” has a lot of historical connotation and trauma, and maybe it isn’t a word we ought to be using in relation to positive commercial tobacco prevention in Native communities. So, how can we use traditions and protective factors in Native culture to promote health?

CS: What part of this job do you find personally satisfying?

RA: Most of my approach is participatory and I think that’s what I like the best. So, working in partnership with whatever community I’m working with. I think each of us brings a different skill and approach to the table and really, it’s the only way we’re going to solve problems; that is by bringing all those skills and approaches together to understand better what’s in front of us and what works in each community.

CS: Thank you, Dr. Rima, we appreciate you taking the time to share your valuable experience with us.

Dr. Rima Afifi can be reached by email rima-afifi@uiowa.edu and on twitter [@rima_justice](https://twitter.com/rima_justice).

Article Dr. Afifi mentioned in her discussion:

Boudreau G, Hernandez C, Hoffer D, Preuss KS, Tibbetts-Barto L, Villaluz NT, Scott S. Why the World Will Never Be Tobacco-Free: Reframing “Tobacco Control” Into a Traditional Tobacco Movement. *Am J Public Health*. 2016 Jul;106(7):1188-95. doi: 10.2105/AJPH.2016.303125. Epub 2016 Apr 14. PubMed PMID: 27077360; PubMed Central PMCID: PMC4984762.

“We do need to consider what our strategies around commercial tobacco control should be in Native communities; strategies that keep the traditional tobacco custom and culture, that engage Native communities in deciding what works for them and how it works for them, and that makes a distinction between traditional tobacco and commercial tobacco.”



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My Journey and the Message

I was in deep despair as I sat alone within my own thoughts. I shall go forth and seek what my ancestors did before me. I shall seek the Creator.

I traveled far and wide while I prayed for guidance. I felt that my prayers went unheard, but as time passed, I learned that the Creator does not work in my time-frame, but in consideration of all. I began to see that my prayers were being heard.

I began to notice the trees dancing in the wind, which I learned was the breath of the Creator. I searched more and more, seeing what was all around me, and realizing that all my life the Creator had been there all along. I began to understand the relationship of Nature and how it all works together, but I wondered, what happened to man? I saw how people would look at differences, so I closed my eyes and began to hear the joys of Nature, but I wondered, what happened to man? I could hear the rushed movements and sounds of hurried drivers honking for others to get going. I covered my ears and began to smell and feel the flowers, trees, and wind, and see how they worked together, but I wondered, what happened to man? I began to smell the scents of oil and smoke of vehicles and companies, the burnt smell of food, and faint smell of wet concrete.

I began to go deeper within myself and found a loudness and an uncomfortable feeling of anger, sadness, and grief. I found a loud silence, my own inner dialogue, so I eventually let it all go and found a profound silence, a peace. Then I heard it, I felt it, I cried a happy cry, as I thought of this message: I Love You. It came from within, but also from all around, from all of Creation. I knew then what happened to man.

Man stopped listening.

Sean Bear

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